PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

On The Record
2019-D11

PROVIDER-
Tulsa Hospitals – See Appendix A

Provider No.: Various – See Appendix A

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

RECORD HEARING DATE –
March 16, 2018

Cost Reporting Period Ended –
2001 - 2009

CASE NOs. – 14-3883G, 14-3890G, 14-3894G, 14-3896G, 14-3897G, 14-3899G, 14-0259 and 14-0266

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ISSUE STATEMENT:[1]

Whether the Medicare Contractor's determination to reduce the Providers' indirect medical education ("IME") and graduate medical education ("GME") full-time equivalent ("FTE") resident counts to exclude certain resident rotations in nonhospital clinics was proper.[2]

DECISION AND ORDER:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor properly reduced the Providers' GME and IME FTE resident counts to exclude resident rotations spent in non-hospital settings for fiscal years ("FYs") at issue.

INTRODUCTION

St. John Medical Center, St. Francis Hospital and Hillcrest Medical Center (the "Providers") are acute care hospitals located in Tulsa, Oklahoma. While the Providers are not commonly owned, they each operate GME programs for interns and residents in various specialty areas in affiliation with the University of Oklahoma/University of Oklahoma College of Medicine (the "University").[3] Novitas Solutions, Inc., the Providers' currently designated Medicare administrative contractor (the "Medicare Contractor")[4] denied the Providers' reimbursement for the GME/IME costs of certain resident rotations spent at non-hospital sites.[5]

The Providers dispute the Medicare Contractor's final determination, which was timely appealed to the Board and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-405.1840 for a hearing. The Board approved a record hearing which was completed on August 15, 2018. The

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[1] All other issues have been withdrawn or transferred to various group appeals.

[2] Parties' Proposed Stipulation of Undisputed Facts and Principles of Law ("Stipulations") at ⁋ 17.

[3] *Id.* at ⁋ 1.

[4] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate. The Providers' initial Medicare contractor was Blue Cross Blue Shield of Oklahoma ("Oklahoma BC/BS") which was succeeded by Chisholm Administrative Services ("Chisholm"). Chisholm was succeeded by TrailBlazer Health Enterprises, LLC ("Trailblazer") and TrailBlazer was succeeded by Novitas Solutions, Inc. ("Novitas"). Stipulations at ⁋ 3. Oklahoma BC/BS, Chisholm, TrailBlazer, and Novitas are collectively referred to as the "Medicare Contractor."

[5] Eight cases encompassing nine fiscal years have been consolidated for hearing. Providers filed a consolidated Final Position Paper for Case Nos. 14-3883G, 14-3890G, 14-3894G, 14-3896G and 14-3897G addressing FYs 2001-2005. Separate Final Position Papers were filed for Case Nos. 14-3899G (FYs 2006-2007), 14-0259 (FY 2008) and 14-0266 (FY 2009). The Medicare Contractor filed a consolidated Final Position Paper for Case Nos. 14-3883G, 14-3890G, 14-3894G, 14-3896G, 14-3897G and 14-3899G (FY 2001-2007) and separate Final Position Papers for Case Nos. 14-0259 and 14-0266 (FYs 2008 and 2009 respectively). For clarity in referencing the various filings in the record, the final position papers and associated exhibits of the parties will be referenced by the fiscal years addressed in the specific filing. Further, the parties entered into an agreement entitled "Parties' Proposed Stipulation of Undisputed Facts and Principles of Law" encompassing all eight consolidated cases. Hereinafter, this document will be referenced simply as the "Stipulations."

Providers were represented by Daniel J. Hettich, Esq. of King & Spalding, L.L.P. The Medicare Contractor was represented by Federal Specialized Services.

STATEMENT OF FACTS:

Each of the Providers in this appeal operates graduate medical education programs for interns and residents in various specialty areas in affiliation with the University.[6] During the cost reporting periods at issue, the Providers, along with a number of other hospitals, were members of the Tulsa Medical Education Foundation, Inc. (the "Foundation").[7] The Providers claimed intern and resident FTEs on their as-filed cost reports for the fiscal years at issue to reflect intern and resident time spent in patient care activities at Nonhospital Clinics in connection with approved medical residency training programs ("Claimed FTEs").[8]

The record in these appeals includes the following undisputed facts. The Providers entered into written Graduate Medical Education Affiliation Agreements ("Affiliation Agreements") with the University.[9] The parties to the Affiliation Agreements were the Providers, the University and the Foundation.[10] Under the terms of the Affiliation Agreement: (1) the Foundation was established to provide a consolidated administrative structure for the training of residents in hospital and nonhospital settings;[11] (2) the Providers funded the costs of the resident training programs through the Foundation;[12] and (3) the Foundation was responsible for collecting the Providers' payments and supplying the funding to the University.[13] Each year, the parties to the Affiliation Agreement executed an Annual Supplemental Agreement ("Supplemental Agreement") setting forth the budget for that year and each members' contribution to the budget.[14] The Supplemental Agreement required each Provider to make monthly payments to the Foundation which then forwarded them to the University.[15] The University employed and compensated all residents training in its residency programs, including those training at the Providers' hospitals, as well as other Provider and non-provider sites.[16] The University prepared the annual budget and associated documents for the GME Programs, including the Supplemental Agreements, which addressed the funding and payment of GME program costs.[17] The

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[6] Stipulations at ¶ 1.
[7] Stipulations at ¶ 5. The Providers claim that "Prior to the establishment of the Foundation, the hospitals separately operated their own residency programs, resulting in numerous inefficiencies and duplication of services. The costs of the residency programs had always been borne by the hospitals, and the Foundation was established simply to coordinate the structure of the various medical residency programs operated by the hospitals in affiliation with the University." Providers' 01-05 Final Position Paper at 4-5. There is no date of establishment of the Foundation in the record before the Board.
[8] Stipulations at ¶¶ 10, 17.
[9] Stipulations at ¶ 8. The University is referred to as the "College" in the Affiliation Agreements.
[10] FYs 2001-2005 Exhibit P-1-a at 1.
[11] Stipulations at ¶ 6. *See also* FYs 2001-2005 Exhibit P-1-a at 2.
[12] FYs 2001-2005 Exhibit P-1-a at 2.
[13] *Id.* at 8.
[14] *See, e.g.*, FYs 2006-2007 Exhibit P-2-a at 2.
[15] *Id.*
[16] *Id.* at 2-3. *See also* FYs 2001-2005 Exhibit P-1-a at 4.
[17] FYs 2006-2007 Exhibit P-2-a at 2.

Supplemental Agreements provided the Providers and the University with a budget for the GME programs for the relevant year and described the agreed-upon mechanism for the Providers to pay the University, through the Foundation, for the salaries and benefits of the residents serving rotations in Nonhospital Clinics.[18] The Providers reported FTE residents based on the proportion of costs that they incurred for the operation of the residency programs related to the residents rotating to Nonhospital Clinics.[19]

In 2007, the Medicare Contractor reopened the Providers' FY 2001 through FY 2006 cost reports, and removed a certain number of FTEs from the Providers' Claimed FTEs[20] based on a determination that the Providers did not comply with the Medicare policy that one hospital must incur "all or substantially all of the costs for a training program in a nonhospital setting" in order to claim any FTE residents rotating to that nonhospital setting.[21]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

The Providers argue that the Medicare Contractor's adjustments should be reversed for three reasons. First, the Providers argue that statutes in place during the relevant cost reporting periods allowed reimbursement to hospitals for medical residency costs for patient care in a nonhospital setting, even when such costs were shared among two or more hospitals.[22] In addition, the Providers assert that Congress expressly revoked the single hospital policy when it enacted § 5504(a) and (b) of the Patient Protection and Affordable Care Act of 2010 ("ACA"),[23] and explicitly allowed this change to all then-pending, jurisdictionally proper appeals.[24] The Providers contend that the appeals were jurisdictionally properly pending before the Board on the date of the ACA enactment, March 23, 2010, and that they are entitled to relief under the law.[25] Finally, the Providers maintain that the Medicare Contractor based its reopening of the FY 2001 through FY 2006 cost reports and denial of the FTEs at issue on a substantive policy change that was implemented without observing the requisite notice and comment rulemaking procedures in violation of § 553 of the Administrative Procedures Act.[26]

Set forth below are the Board's findings with respect to each of these arguments.

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[18] *Id.*
[19] Providers' FYs 2006-2007 Final Position Paper at 6.
[20] Stipulations at ¶ 13.
[21] Stipulations at ¶ 15.
[22] Providers' FYs 2001-2005 Final Position Paper at 26-27; Providers' FYs 2006-2007 Final Position Paper at 26-27.
[23] Pub. L. No. 111-148, 124 Stat. 119, 659-660 (Mar. 23, 2010).
[24] Providers' FYs 2001-2005 Final Position Paper at 21-23.
[25] *Id.*
[26] *Id.* at 35-38.

A. REQUIREMENT FOR PAYMENT OF ALL OR SUBSTANTIALLY ALL OF THE GME PROGRAM COSTS, WHEN SUCH COSTS WERE SHARED AMONG TWO OR MORE HOSPITALS

The Providers assert that FTEs for "residents rotating to 'shared' nonhospital settings must be included under the law and regulations in place during the fiscal years under appeal."[27] According to the Providers, "the IME and GME statutes and regulations during the relevant timeframe mandated that a hospital is entitled to count all of the time spent by an intern or resident in a nonhospital setting if: (1) the resident is engaged in patient care activities; (2) the resident is in an approved medical residency training program and (3) the hospital incurs all or substantially all of the costs for the training program in that setting."[28] The Providers state that, without question, they have met all three of these requirements and that the time the residents spend at a nonhospital setting is to be included in the GME and IME FTE count.[29] In regards to incurring all the costs of training a resident, the Provider believes that multiple hospitals can share in providing substantially all the costs in a nonhospital setting. The Provider states that, "[p]rior to CMS's informal clarification in 2003, Medicare contractors routinely paid hospitals for shared residency training costs and courts held that CMS's clarification thwarted Congress's intent."[30]

The Board disagrees with the Providers' contention that, because each of them paid and claimed a proportional share of the costs associated with the residency programs, they each met the statutory requirement that "the hospital incurs all, or substantially all, of the costs for the training program in that setting."[31] For GME/IME reimbursement purposes, 42 U.S.C. §§ 1395ww(h)(4)(E) and 1395ww(d)(5)(B)(iv) entitle a hospital to count the time its residents spend providing patient care activities in non-hospital settings, *only* if "*the hospital incurs all, or substantially all, of the costs* ***for the training program*** in that [nonhospital] setting."[32] During the fiscal years at issue, federal regulations located at 42 C.F.R. § 413.86(b) (2003)[33] defined the term "all or substantially all of the costs for the training program in the nonhospital setting" to mean "the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries and fringe benefits attributable to direct graduate medical education."[34] In this case, the evidence in the record demonstrates that

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[27] *Id.* at 25-26.
[28] *Id.* at 26, citing to 42 U.S.C. §§ 1395ww(d)(5)(B)(iv), 1395 ww(h); 42 C.F.R. §§ 413.75, 413.78, 412.105.
[29] Providers' FYs 2001-2005 Final Position Paper at 26-27.
[30] *Id*. at 27.
[31] *Id*. at 26-27.
[32] Emphasis added.
[33] With respect to cost reporting periods on or after October 1, 2004, § 413.86(b) was redesignated as § 413.75(b) without any substantive changes pertinent to this appeal.
[34] In 2007, the definition of "all or substantially all of the costs for the training program in the nonhospital setting" set forth in § 413.75(b) was amended, for cost periods beginning on or after July 1, 2007, to mean, "at least 90 percent of the total of the costs of the residents' salaries and fringe benefits (including travel and lodging where applicable) and the portion of the cost of teaching physicians' salaries attributable to nonpatient care direct GME activities." *See* 72 Fed. Reg. 26869, 26976 (May 11, 2007). Again, this amendment does not alter the Board's opinion.

none of the individual Provider hospitals paid "all or substantially all of the costs for the [entire] training program" in the University nonhospital settings.[35]

The Providers claim that "[n]othing in the applicable statutory language stated that hospitals may not share the burden of incurring all or substantially all of the costs of a training *program* (versus an individual resident) in a nonhospital setting."[36] The Board disagrees and finds that this financial arrangement did not comply with unambiguous language of the controlling federal statutes and regulations. Although each Provider hospital can demonstrate that it incurred costs related to a portion of *the residents* rotating through the residency training program, none of the Provider hospitals met the requirement that it individually, incurred "all or substantially all of the costs for *the training program. . . .*"[37]

In support of its finding, the Board notes that CMS has issued multiple guidance statements covering the time period at issue (*i.e.*, 2001 to 2006) confirming CMS' single hospital policy, *i.e.*, that CMS has interpreted the relevant GME/IME statutory provisions to disallow GME/IME reimbursement when two or more hospitals split the costs of nonhospital training. In the preamble to the final rule issued on July 31, 1998, CMS stated that:

> Under sections 1886(d)(5)(B)(iv) and 1886(h)(4)(E) of the Act, *a hospital* may include the time a resident spends in nonprovider settings in its indirect medical education (IME) and direct GME full-time equivalent count *if it incurs* "all or substantially all" of the costs of training residents in the nonhospital site.[38]

Similarly, in the preamble to final rule issued on August 1, 2003, CMS states:

> We note that, under existing policy, to count residents in a nonhospital setting, **a hospital is required to incur** for ''all or substantially all of the costs of the *program*'' **in that setting**. In

[35] 42 U.S.C. §§ 1395ww(h)(4)(E), 1395ww(d)(5)(B)(iv).
[36] Providers' FYs 2005-2007 Final Position Paper at 28 (emphasis in original).
[37] 42 U.S.C. §§ 1395ww(h)(4)(E) and 1395ww(d)(5)(B)(iv) (emphasis added).
[38] 63 Fed. Reg. 40954, 40986 (July 31, 1998) (emphasis added). *See also id.* at 40988 ("Currently, hospitals may receive payment for the time residents spend in the nonhospital setting if *the hospital incurs* 'all or substantially all' of the training costs. We proposed to adopt a similar policy for qualified nonhospital providers; that is, *a qualified nonhospital provider* may receive payment for the direct costs of GME if *it incurs* 'all or substantially all' of the training costs." (emphasis added)). Finally, in the context of qualified ***non***hospital providers, CMS rejects allowing allocation of training costs between itself and other providers because it would be inconsistent with its nonhospital training policy for hospitals as shown by the following 2 excerpts from the 1998 final rule: (1) "Although we proposed to pay *the qualified nonhospital provider* only when *it incurred* 'all or substantially all' of the costs of training, we solicited comment on possible methods for allocating the GME payments for training in the nonhospital site where neither the hospital nor the qualified nonhospital provider is incurring 'all or substantially all' of the costs of the training program." *Id.* at 40986 (emphasis added); (2) "[A]lthough it may be appropriate to provide payment for GME costs where the nonhospital site incurs only a portion of the training costs, we do not believe it would be equitable to allow *a nonhospital site* to be paid where *it was incurring* only a portion of the costs but only allow payment to *a hospital* when *it incurs* 'all or substantially all' of the costs." *Id.* at 40995 (emphasis added).

> other words, a hospital is required to assume financial responsibility for the *full* complement of residents training in a nonhospital site in a particular program in order to count any FTE residents training there for purposes of IME payment. **A hospital** cannot count any FTE residents if **it incurs** ''all or substantially all of the costs'' for **only a portion** of the FTE residents in that program training setting. This policy is derived from the language of the IME and direct GME provisions of the statute on counting residents in nonhospital settings; both sections 1886(d)(5)(B)(iv) and 1886(h)(4)(E) of the Act state that the hospital must incur ''all, or substantially all, of the costs for the training *program* in that setting.'' (Emphasis added.)[39]

As a result, 42 C.F.R. § 413.78(e)(2) (2005)[40] specifies that a hospital cannot count the time residents spend in nonhospital settings, such as clinics, in its GME/IME FTE count, unless "*the hospital . . . incur[s]* all or substantially all of the costs *for the training program* in a nonhospital setting."[41]

In the preamble to the final rule published on August 22, 2014 (the "August 2014 Final Rule"), CMS included a section entitled "Clarification of Policies on Counting Resident Time in Nonprovider Settings Under Section 5504 of the Affordable Care Act."[42] In this section, CMS discussed at length the "longstanding substantive standard" which allowed hospitals to count FTEs for residents' training time if the one single hospital which sponsored the residency and then claimed GME and IME FTEs for the program also incurred all or substantially all of the costs for the training. CMS referred readers to final rules from 1998, 2003 and 2007.[43] In this regard, the Board notes that, in the final rule published on May 11, 2007, CMS included the following discussion on its interpretation of the GME/IME requirements:

> [U]nder the new definition of "all or substantially all," whether hospitals pay for the costs of a program at a nonhospital site on a concurrent basis, or if they have a written agreement, they must be able to document how they are paying for "all of substantially all" of the costs of a particular program at each nonhospital site. . . . Similarly, as under current policy, **if two (or more) hospitals train residents in the same accredited program, and the**

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[39] 68 Fed. Reg. 45346, 45439 (Aug. 1, 2003) (Italics emphasis in original and bold and underline emphasis added.)
[40] This regulation was originally codified at 42 C.F.R. § 413.86(f) and was redesignated as § 413.78(f) without substantive changes for cost reporting periods on or after October 1, 2004. *See* 69 Fed. Reg. 48916, 49111-49112, 49235-49236, 49254, 49258 (Aug. 11, 2004). 42 C.F.R. § 412.105(f)(1)(ii)(C) incorporates these GME requirements (as originally codified and later redesignated) into the IME requirements. *See id*. at 49244-49245.
[41] (Emphasis added.) The Board further notes that 42 U.S.C. § 1395ww(d)(5)(B)(iv) similarly includes that condition that "***the hospital incurs*** all, or substantially all, of the costs ***for the training program*** in that [nonhospital] setting." (Emphasis added.)
[42] 79 Fed. Reg. 49854, 50117 (Aug. 22, 2014).
[43] *See id.* at 50117-50122.

> **residents rotate to the same nonhospital site(s), <u>the hospitals cannot share the costs</u> of that program at that nonhospital site** (for example, by dividing the FTE residents they wish to count according to some predetermined methodology), as we do not believe this is consistent with the statutory requirement at section 1886(h)(4)(E) of the Act which states that the hospital incur *"all, or substantially all, of the cost for the training program in that setting."*[44]

In this case, the Providers concede that none of the individual hospitals incurred "all or substantially all" of the costs for the training programs in the nonhospital settings, as that term is defined in the regulations.[45] Rather, the Providers make proportional payments to the University, through the Foundation, to reimburse the University and other training programs for the total program costs based on the resident allocation schedule.[46] Contrary to the Providers' arguments, paying a proportional share of residency program costs does not meet the requirements set forth at 42 U.S.C. §§ 1395ww(h)(4)(E), 1395ww(d)(5)(B)(iv) or 42 C.F.R. § 413.78(e)(2).

The District Court for the District of Columbia in *Borgess Med. Ctr. v. Sebelius* ("*Borgess*")[47] addressed CMS' interpretation of the "all or substantially all" language at the core of this case. The *Borgess* court found that Congress did not specifically speak to the issue of whether the "all or substantially all" language precluded the sharing of costs between two or more hospitals.[48] However, the court concluded that the statutes "are reasonably read to require the Secretary to disallow reimbursement where two or more hospitals split the costs of nonhospital training."[49] The court further found that the Secretary has proffered this interpretation as far back as 1998.[50] The Providers in this case, like the providers in *Borgess*, share the cost of the residency programs in proportion to their FTE residents training at the nonhospital sites which does not meet the requirements of 42 U.S.C. §§ 1395ww(h)(4)(E) and 1395ww(d)(5)(B)(iv) or 42 C.F.R. § 413.86(f)(4)(iii).[51]

B. FINDINGS RELATING TO THE APPLICATION OF ACA § 5504

The Providers' second argument is that "Section 5504(c) of the ACA effectively mandates that, if a hospital has a jurisdictionally proper appeal pending as of the date of enactment (March 23, 2010), its cost report must be reopened with respect to IME and GME to adjust a provider's FTE count in accordance with the statutory amendments."[52] As explained below, the Board finds that

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[44] 72 Fed. Reg. 26870, 26969 (May 11, 2007) (italics emphasis in original and bold and underline emphasis added).
[45] Stipulations at ¶ 18.
[46] *See* FYs 2001-2005 Exhibit P-1-a at 8.
[47] 966 F. Supp. 2d 1 (D.D.C. 2013), *aff'd sub nom, Borgess v. Burwell*, 843 F.3d 497 (D.C. Cir. 2016).
[48] *Id.* at 6.
[49] *Id.*
[50] *Id.* at 6-7 (citing language at 63 Fed. Reg. 40954, 40986 (July 31, 1998)).
[51] Stipulations at ¶ 18.
[52] Providers' FYs 2001-2005 Final Position Paper at 21.

the Providers have misinterpreted the mandate of ACA § 5504(c) and, therefore, rejects the Providers' argument on this issue.

With respect to GME, ACA § 5504(a) amended 42 U.S.C. § 1395ww(h)(4)(E) to allow a hospital to count *all* of the time that a resident trains in a nonhospital site so long as the hospital incurs the costs of the resident's salaries and fringe benefits for the time that the resident spends training in the nonhospital site. This amendment also removed the requirement for hospitals to have a written agreement with the non-hospital setting, and the requirement for the sponsoring hospital to incur the costs for supervisory teaching activities.[53] ACA § 5504(b) made similar amendments to 42 U.S.C. § 1395ww(d)(5)(B)(iv) to apply these policy changes to IME reimbursement as well. Both subsections (a) and (b) of § 5504 specify that they are effective prospectively for cost reporting periods or discharges on or after July 1, 2010.[54]

ACA § 5504(a) and (b) are significant to the Providers' appeal in that these statutory amendments specifically, and for the first time, allow for hospitals that share the costs of residency training programs to claim a proportion of the shared program costs on their cost reports through the following operative language:

> [E]ffective for cost reporting periods beginning on or after July 1, 2010, all the time so spent by a resident shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if a hospital incurs the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting. *If more than one hospital incurs these costs, either directly or through a third party, such hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.*[55]

The Board finds that, while § 5504(a) and (b) permit hospitals that share the costs of residency training programs to qualify, under certain circumstances, to include a proportion of those costs incurred on their cost reports, these subsections are not applicable to the fiscal years at issue. Specifically, Congress was clear that the new ACA §§ 5504(a) and (b) only applied to cost reporting periods beginning on or after July 1, 2010, and could only be applied prospectively.[56]

The Board next turns to § 5504(c) as it provides for additional permissible applications of §§ 5504(a) and (b):

> (c) Application.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled

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[53] ACA § 5504(a).
[54] *See* 42 U.S.C. §§ 1395ww(d)(5)(B)(iv), 1395ww(h)(4)(E)(ii).
[55] ACA § 5504(a)(3) (emphasis added). ACA § 5504(b)(2) has this same language verbatim.
[56] *See* 42 U.S.C. §§ 1395ww(d)(5)(B)(iv), 1395ww(h)(4)(E)(ii).

> hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h)).[57]

However, as explained below, CMS has made it clear that § 5504(c) does not mandate reopening of cost reports or specify that §§ 5504(a) and (b) must (or should) be applied to IME/GME appeals pending as of the date of enactment of ACA.

As part of the final rule published on November 24, 2010 (the "November 2010 Final Rule"), CMS promulgated regulations at 42 C.F.R. §§ 413.78(g) and 412.105(f)(1)(ii)(E) to implement ACA § 5504.[58] The regulatory language of 42 C.F.R. § 413.78(g)(6) (2010) as promulgated in 2010 would arguably support the Provider's position:[59]

> The provisions of paragraphs (g)(1)(ii), (g)(2), (g)(3), and (g)(5) of this section cannot be applied in a manner that would require the reopening of settled cost reports, *except* those cost reports on which there is a jurisdictionally proper appeal pending on direct GME or IME payments as of March 23, 2010.[60]

However, as part of the preamble to the November 2010 Final Rule, CMS stated that § 5504(c) was not intended to permit the retroactive application of the amendments in §§ 5504(a) and (b) to apply to pending appeals before the Board:

> [S]ection 5504 is fully prospective, with an explicit effective date of July 1, 2010, for the new standards it creates. Nothing in section 5504(c) overrides that effective date. Section 5504(c) merely notes that the usual discretionary authority of Medicare contractors to reopen cost reports is not changed by the provisions of section 5504; it simply makes clear that Medicare contractors are not required by reason of section 5504 to reopen any settled cost report as to which a provider does not have a jurisdictionally proper appeal pending. It does not require reopening in any circumstance; and the new substantive standard is, in any event, explicitly prospective. We believe if Congress had wanted to require such action or to apply the new standards to cost years or discharges

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[57] ACA § 5504(c).
[58] 75 Fed. Reg. 71800, 72134-39 (Nov. 24, 2010).
[59] For a more complete discussion, *see* the Board's decision in *Eastern Maine Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2014-D10 (June 2, 2014), *rev'd*, CMS Adm'r Dec. (July 23, 2014).
[60] *See* 75 Fed. Reg. at 72262 (emphasis added).

> prior to July 1, 2010, it would have done so in far more explicit terms.[61]

CMS later recognized the potential confusion around the 2010 regulation. Specifically, as part of the preamble to the August 2014 Final Rule, CMS included a section entitled "Clarification of Policies on Counting Resident Time in Nonprovider Settings Under Section 5504 of the Affordable Care Act."[62] In this section, CMS addressed the retroactivity of the newly granted latitude in claiming FTEs under ACA §§ 5504(a) and (b), stating that "[t]he introductory regulatory language of 413.78(g) explicitly states that paragraph (g) governs only 'cost reporting periods beginning on or after July 1, 2010.' . . . whereas earlier cost reporting periods are governed by other preceding paragraphs of 413.78."[63] Further, CMS explicitly clarified that § 5504(c) was not intended to permit the retroactive application of the §§ 5504(a) and (b) amendments to pending appeals before the Board:

> Accordingly, we believe that it is apparent that the provisions of sections 5504(a)(3) and (b)(2) of the Affordable Care Act are not to be applied prior to July 1, 2010, irrespectively of whether a hospital may have had a jurisdictionally proper pending appeal pending as of March 23, 2010, on an IME or direct GME issue from a cost reporting period occurring prior to July 1, 2010.[64]

In making this clarification, CMS recognized that "the existing regulation text . . . [at § 413.78(g)(6)] was not written in a manner that is as consistent with section 5504(c) of the Affordable Care Act and reflective of our reading of section 5504 and our policy as it could be."[65] Accordingly, CMS modified 413.78(g)(6) to read as follows and specified that these changes applied retroactively to July 1, 2010[66]:

> The provisions of paragraphs (g)(1)(ii), (g)(2), (g)(3), and (g)(5) of this section shall not be applied in a manner that requires reopening of any settled cost reports as to which there is not a jurisdictionally proper appeal pending as of March 23, 2010, on direct GME or IME payments. Cost reporting periods beginning before July 1, 2010 are not governed by paragraph (g) of this section.

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[61] *Id*. at 72136.
[62] 79 Fed. Reg. 49854, 50117-50122 (Aug. 22, 2014).
[63] *Id.* at 50118. CMS also discussed at length the "longstanding standard" which allowed hospitals to count FTEs for residents' training time if the one single hospital which sponsored the residency and then-claimed GME and IME FTEs for the program also incurred all or substantially all of the costs for the training and, in support of this assertion, cites to final rules from 1998, 2003 and 2007. *See id.*at 50117-50122.
[64] *Id.* at 50119.
[65] *Id.* at 50118.
[66] *See id.* at 50120-50122.

Based on CMS' clarification in the August 2014 Final Rule, the Board must conclude that ACA § 5504 is not applicable to the subject appeals because the fiscal years at issue in these cases began before July 1, 2010. While the Board recognizes that the decision in this case conflicts with its 2014 decision in *Eastern Maine Med. Ctr. v. Blue Cross Blue Shield Ass'n* ("*Eastern Maine*"),[67] the Board notes that CMS clarified the regulation in the August 2014 Final Rule *subsequent* to the Board's decision in *Eastern Maine.*

The Board's legal conclusion in this case is consistent with the Board's decisions in similar cases that were issued *subsequent* to *Eastern Maine*.[68] In support of the Board's legal conclusion, these decisions also reference the U.S. Court of Appeals for the Sixth Circuit in *Covenant Med. Ctr., Inc. v. Burwell* ("*Covenant*")[69] which upheld CMS' regulatory clarification in the August 2014 Final Rule to preclude retroactive application of ACA § 5504 (a) and (b).[70]

C. ADMINISTRATIVE PROCEDURES ACT IS NOT VIOLATED BY THE MEDICARE CONTRACTOR'S ADJUSTMENTS

Finally, the Providers maintain that the reopening of the FYs 2001 through 2006 cost reports to deny reimbursement in these cases represents the application of a substantive policy change that was implemented without observing the requisite notice and comment rulemaking procedures, in violation of APA § 553.[71] The Board finds that this argument has no merit. The Medicare Contractor exercised its proper, unreviewable,[72] discretion to reopen the Providers' FY 2001 through 2006 cost reports to apply regulations properly promulgated by CMS.

As explained in Subsection A of the Findings Section of this Decision, there was no substantive policy change regarding the definition of "all or substantially all" costs when costs were shared by more than one hospital. For the years prior to ACA § 5504, CMS has consistently interpreted the rules to require one hospital to incur the costs of a residency training program before that hospital could claim FTEs on its cost report. The Secretary properly promulgated regulations to effect Congressional amendments to the GME/IME reimbursement statute. CMS is not bound by the actions of Medicare contractors that failed to follow CMS interpretations in the past.

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[67] PRRB Dec. No. 2014-D10 (June 2, 2014), *rev'd*, CMS Adm'r Dec. (July 23, 2014).
[68] *See, e.g., Lutheran Hosp. of Fort Wayne Indiana v. Wisconsin Physicians Servs.*, PRRB Dec. No. 2015-D13 (Aug. 4, 2015), *declined review*, CMS Adm'r (Sept. 22, 2015); *Integris/Deaconess 2005 Non-Provider Setting IME/GME CIRP Grp. v. Novitas Solutions, Inc.*, PRRB Dec. No. 2016-D14 (June 7, 2016), *declined review*, CMS Adm'r (Aug. 1, 2016).
[69] 603 Fed. Appx. 360 (6th Cir. 2015) (involving FYs 2002 to 2006).
[70] *Id*. at 364. *See also Eastern Maine Med. Ctr. v. Burwell*, 159 F. Supp. 3d 109 (D. Me. 2016).
[71] Providers' FYs 2001-2005 Final Position Paper at 35-38.
[72] *See* 42 C.F.R. § 405.1885(a)(6).

DECISION:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor properly reduced the Providers' GME and IME FTE resident counts to exclude resident rotations spent in non-hospital settings for the fiscal years at issue.

BOARD MEMBERS PARTICIPATING:

Clayton J. Nix, Esq.
Charlotte F. Benson, C.P.A.
Gregory Ziegler, C.P.A, C.P.C-A
Robert Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

1/25/2019

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

APPENDIX A

Schedule of Providers in Group

Group Name: Tulsa Hospitals 2001 GME Group
Representative King & Spalding
Case No: 14-3883G

Page No. 1 of 1
Date Prepared 10/30/2015

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Issue: Whether the MAC's determination to reduce the Providers' IME and GME FTE resident counts to exclude resident rotations in nonhospital settings was proper.

Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
1 37-0091	Saint Francis Hospital (Tulsa, Tulsa, OK)	Novitas Solutions, Inc.	6/30/2001 (R)	3/7/2014	8/6/2014	152	1, 2, 3, 4, 5, 6	$24652	Direct Add	8/6/2014
2 37-0114	St. John Medical Center, Inc. (Tulsa, Tulsa, OK)	Novitas Solutions, Inc.	9/30/2001 (R)	3/7/2014	8/6/2014	152	1, 2, 3, 4, 5, 6	$41043	Direct Add	8/6/2014

Total Amount of Reimbursement: $65695

Schedule of Providers in Group

Group Name: Tulsa Hospitals 2002 GME Group
Page No. 1 of 1
Representative King & Spalding
Date Prepared 10/30/2015
Case No: 14-3890G
Issue: Whether the MAC's determination to reduce the Providers' IME and GME FTE resident counts to exclude resident rotations in nonhospital settings was proper.

	Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
1	37-0001	Hillcrest Medical Center (Tulsa, Tulsa, OK)	Novitas Solutions, Inc.	6/30/2002 (R)	3/7/2014	8/6/2014	152	1, 2, 3, 4, 5, 6	$134620	Direct Add	8/6/2014
2	37-0091	Saint Francis Hospital (Tulsa, Tulsa, OK)	Novitas Solutions, Inc.	6/30/2002 (R)	3/7/2014	8/6/2014	152	1, 2, 3, 4, 5, 6	$682821	Direct Add	8/6/2014
3	37-0114	St. John Medical Center, Inc. (Tulsa, Tulsa, OK)	Novitas Solutions, Inc.	9/30/2002 (R)	3/7/2014	8/6/2014	152	1, 2, 3, 4, 5, 6	$49864	Direct Add	8/6/2014

Total Amount of Reimbursement: $867305

Schedule of Providers in Group

Group Name: Tulsa Hospitals 2003 GME Group
Page No. 1 of 1
Representative King & Spalding
Date Prepared 10/30/2015
Case No: 14-3894G
Issue: Whether the MAC's determination to reduce the Providers' IME and GME FTE resident counts to exclude resident rotations in nonhospital settings was proper.

	Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
1	37-0001	Hillcrest Medical Center (Tulsa, Tulsa, OK)	Novitas Solutions, Inc.	6/30/2003 (R)	3/7/2014	8/6/2014	152	1, 2, 3, 4, 5, 6	$258772	Direct Add	8/6/2014
2	37-0091	Saint Francis Hospital (Tulsa, Tulsa, OK)	Novitas Solutions, Inc.	6/30/2003 (R)	3/7/2014	8/6/2014	152	1, 2, 3, 4, 5, 6	$1286587	Direct Add	8/6/2014
3	37-0114	St. John Medical Center, Inc. (Tulsa, Tulsa, OK)	Novitas Solutions, Inc.	9/30/2003 (R)	3/7/2014	8/6/2014	152	1, 2, 3, 4, 5, 6	$49437	Direct Add	8/6/2014

Total Amount of Reimbursement: $1594796

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[redacted]

Schedule of Providers in Group

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Group Name: Tulsa Hospitals 2004 GME Group
Page No. 1 of 1
Representative King & Spalding
Date Prepared 10/27/2015
Case No: 14-3896G
Issue: Whether the MAC's determination to reduce the Providers' IME and GME FTE resident counts to exclude resident rotations in nonhospital settings was proper.

	Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
1	37-0001	Hillcrest Medical Center (Tulsa, Tulsa, OK)	Novitas Solutions, Inc.	6/30/2004 (R)	3/7/2014	8/6/2014	152	1, 2, 3, 4, 5, 6	$500623	Direct Add	8/6/2014
2	37-0091	Saint Francis Hospital (Tulsa, Tulsa, OK)	Novitas Solutions, Inc.	6/30/2004 (R)	3/7/2014	8/6/2014	152	1, 2, 3, 4, 5, 6	$1855321	Direct Add	8/6/2014

Total Amount of Reimbursement: $2355944

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Schedule of Providers in Group

Group Name: Tulsa Hospitals 2005 GME Group
Representative King & Spalding
Case No: 14-3897G

Page No. 1 of 1
Date Prepared 10/27/2015

Issue: Whether the MAC's determination to reduce the Providers' IME and GME FTE resident counts to exclude resident rotations in nonhospital settings was proper.

	Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
1	37-0001	Hillcrest Medical Center (Tulsa, Tulsa, OK)	Novitas Solutions, Inc.	6/30/2005 (R)	3/7/2014	8/6/2014	152	1, 2, 3, 4, 5, 6	$236433	Direct Add	8/6/2014
2	37-0091	Saint Francis Hospital (Tulsa, Tulsa, OK)	Novitas Solutions, Inc.	6/30/2005 (R)	3/7/2014	8/6/2014	152	1, 2, 3, 4, 5, 6	$1812514	Direct Add	8/6/2014

Total Amount of Reimbursement: $2048947

Schedule of Providers in Group

Group Name: Tulsa Hospitals 2006-2007 GME Group
Representative King & Spalding
Case No: 14-3899G

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Date Prepared 11/14/2016

Issue: Whether the MAC's determination to reduce the Providers' IME and GME FTE resident counts to exclude resident rotations in nonhospital settings was proper.

	Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
1	37-0001	Hillcrest Medical Center (Tulsa, Tulsa, OK)	Novitas Solutions, Inc. - JH	6/30/2006	3/7/2014 (R)	8/6/2014	152	1, 2, 3, 4, 5, 6	$708954	Direct Add	8/6/2014
2	37-0091	Saint Francis Hospital (Tulsa, Tulsa, OK)	Novitas Solutions, Inc. - JH	6/30/2006	3/7/2014 (R)	8/6/2014	152	1, 2, 3, 4, 5, 6	$2224071	Direct Add	8/6/2014
3	37-0091	Saint Francis Hospital (Tulsa, Tulsa, OK)	Novitas Solutions, Inc. - JH	6/30/2007	6/25/2009	12/9/2009	167	49, 50	$2045474	10-0223	12/1/2015

Total Amount of Reimbursement: $4978499